

Domain 4 Team

- Kristi Pier, Principal Investigator
- Kathy Graham, 1305 Program Coordinator
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Overview

- Successes and challenges
- Partner engagement
- Work plan activities in action
- Sustainability



1305 Diabetes Prevention and Management Strategies

Basic

- Promote awareness of prediabetes among people at risk for type 2 diabetes
- Increase use of and promote participation in diabetes management programs

Enhanced

- Increase access, referrals, and reimbursement for diabetes management programs
- Increase use of the Diabetes Prevention Program
- Increase use of health care extenders for self-management of high blood pressure and diabetes



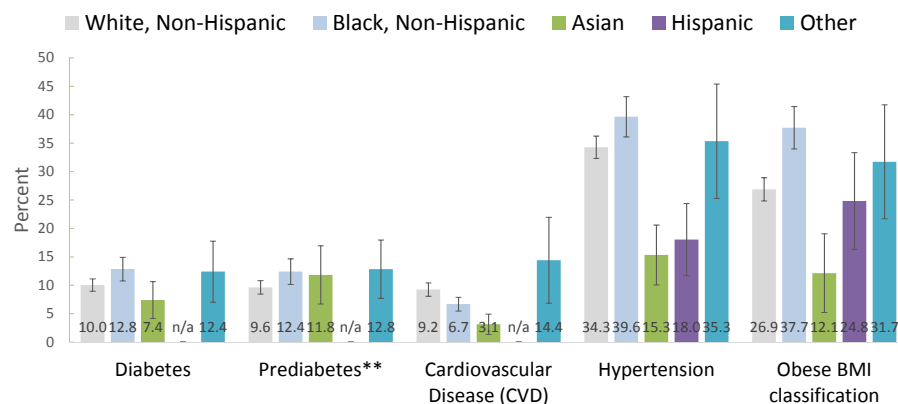
Maryland's Approach

- Build partnerships
- Build capacity and infrastructure—new and existing programs
- Develop and expand referral systems—increasing access
- Facilitate program provider reimbursement—sustainable funding mechanism
- Leverage other funds (PHHS, state funds)



Prevalence of Chronic Health Conditions by Race/Ethnicity

Source: Maryland 2015 Behavioral Risk Factor Surveillance System



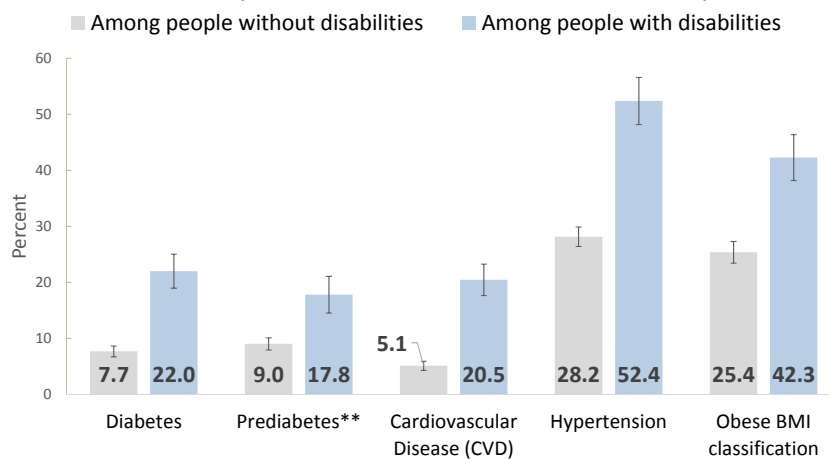
**Prediabetes data is from the MD 2014 BRFSS



What about Chronic Disease and Disability in Maryland?

Prevalence of Chronic Health Conditions by Disability Status

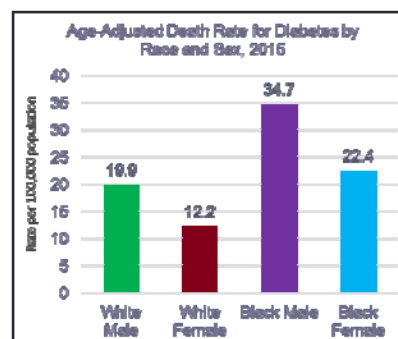
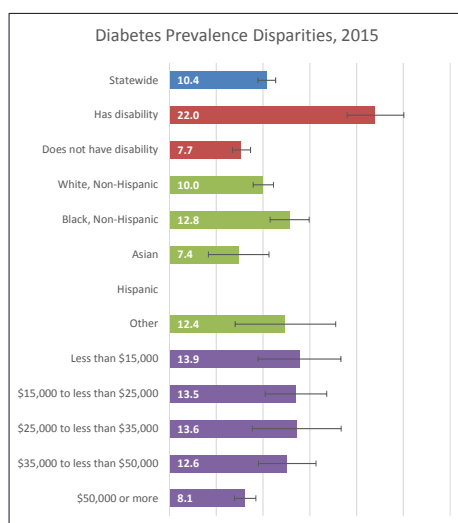
Source: Maryland 2015 Behavioral Risk Factor Surveillance System



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Diabetes Disparities



Source: Maryland Behavioral Risk Factor Surveillance System, 2015;
Maryland Vital Statistics Administration, Maryland Vital Statistics
Annual Report, 2015



Key Partnerships in Domain 4

- State Partners
 - Maryland Department of Aging
 - Center for Tobacco Prevention and Control
 - Maryland Medicaid
- Local Partners
 - Health departments
 - Community-based organizations
 - Network of DPP providers
 - Network of Area Agencies on Aging (CDSMP/DSMP)



Promote Awareness – Be Healthy Maryland

The image displays two screenshots of the BeHealthyMaryland.org website. The left screenshot shows the homepage with a navigation bar, a search bar, and a 'Find a Diabetes Self-Management Program' banner. The right screenshot shows a detailed view of the 'Find a Class' section, including a map of Maryland and a list of classes.



Promote Awareness - Successes

- BeHealthyMaryland.org website
- Health care provider education
 - Six grants to LHDs
 - MAC, Inc.
- Public awareness campaigns
 - Self-management
 - Prevention



Diabetes Self-Management Ad

- <https://www.youtube.com/watch?v=bZXmVrR8aHM>



Promoting Awareness - Challenges

- Health care provider education and referrals
 - Reaching health care providers
 - Consistency in making referrals
- Measuring effectiveness of public campaigns
 - Limited ability to measure effectiveness - website hits
 - Outcomes – Are people signing up?
 - Which communication methods work best?



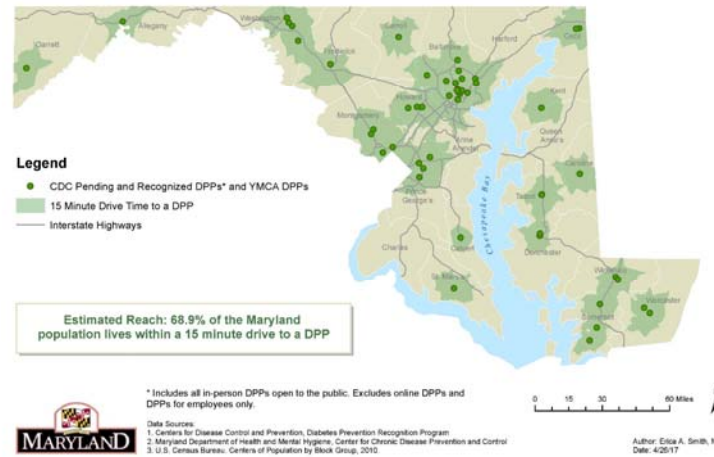
Access and Referrals - Successes

- Healthiest Maryland Businesses
- CDSMP/DSMP classes, locations, and participants
- Six LHDs developed new DPP providers
- Quality Improvement in Health Systems grants



Access and Referrals - Successes

Diabetes Prevention Program (DPP) Access in Maryland: 15 Minute Drive Time Analysis

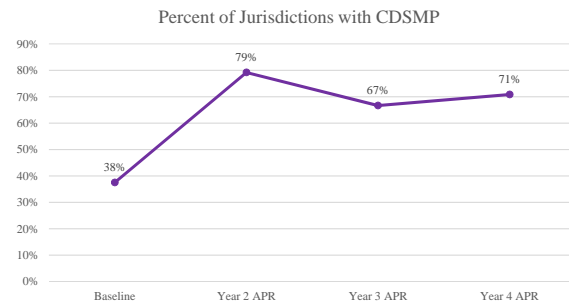
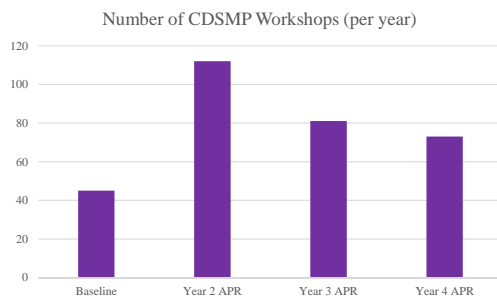


Access and Referrals - Challenges

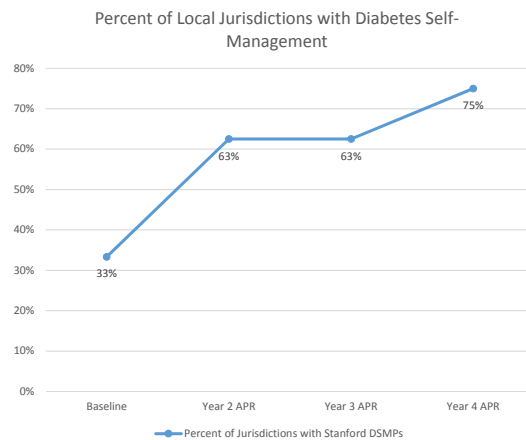
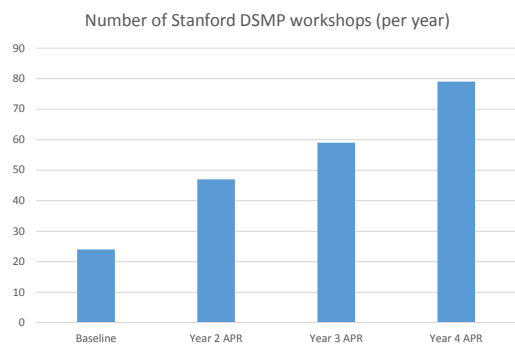
- Starting new programs
 - Staffing and budget constraints
- DSME barriers*
 - Getting referrals from health care providers and insurers
 - Participant co-pays and deductibles
 - Transportation and caregiving
 - Lack of convenient locations

*DSME Partner Survey, 2017

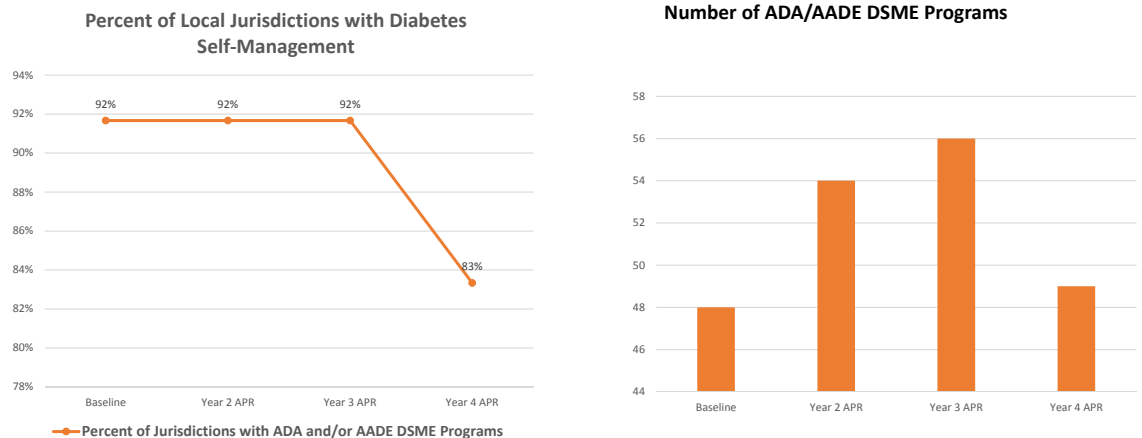
Program Data - CDSMP



Program Data – DSMP



Program Data DSME

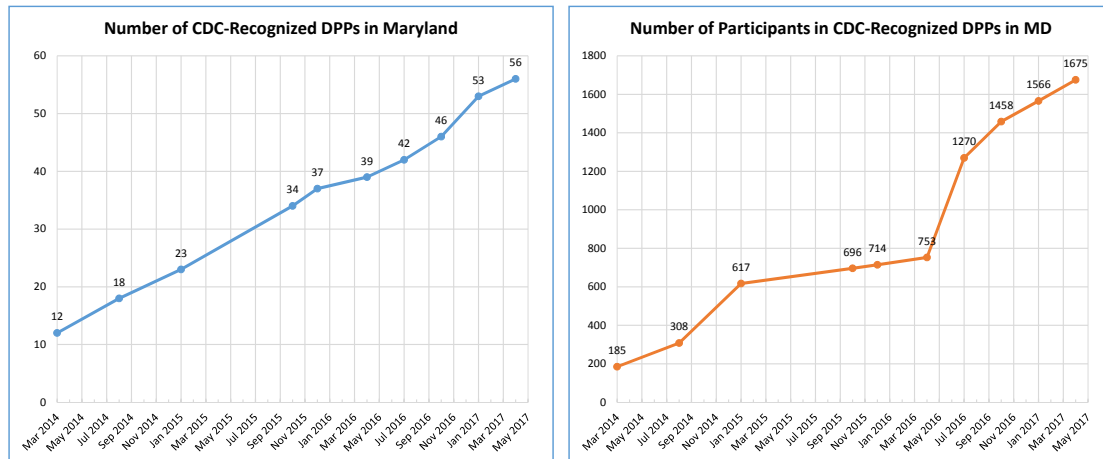


DPP Program Data – Six LHD grants

- Lifestyle Coaches Trained - 21
- New NDPP providers 5, 1 with expanded capacity
- Number of new classes - 16
- Number of Participants enrolled - 208
- Number of health systems engaged - 11



DPP Program Data



Health Care Extenders

- Pharmacists
- Community Health Workers



Sustainability - Successes

- Insurance and Employer Coverage for DPP
- Leveraging Other Funds
- Be Healthy Maryland/Workshop Wizard



Sustainability - Challenges

- Insurance and Employer Coverage for DPP
- Be Healthy Maryland/Workshop Wizard
- Referral Streams



DSMP and CDSMP Overview

- CDSMP/DSMP history in Maryland
- MDH and MAC collaboration



**Expanding Access to CDSMP and DSMP Programs
and Assisting the Aging Network to Build Referral
Systems
with Health Care Providers and
Collaborate with Local Health Departments**

MAC, Inc. Living Well Center of Excellence

Leigh Ann Eagle, Executive Director

Sue Lachenmayr, State Program Coordinator



MAC, Inc. Living Well Center of Excellence

Who We Are

- Area Agency on Aging serving Lower Eastern Shore (four counties)
- Designated as LWCE by MDoA to maintain/expand CDSME statewide infrastructure
- Statewide Stanford license
- Statewide database for participant data and referrals
- Leader trainings
- Fidelity/quality assurance oversight

What We Do

- Provide tools and technical assistance to community partners
- Track referrals and provide feedback
- Quarterly reporting of completers and quality assurance metrics
 - Includes patient engagement measures and evaluation of leader skills
- Beneficiary and population outcomes



MAC and MDH Collaboration

- Engage aging network partners (AAAs), Local Health Departments and Health Care entities to implement/expand access to CDSME workshops
- Track and report partnership progress and reach
- Provide webinars to increase provider awareness/community engagement
- Provide trainings to expand capacity of CDSME programs
- Track referrals to CDSME programs and completers



Reaching Individuals with Diabetes – DSMP and CDSMP (2013-2017)

DSMP

- 236 workshops
- Number who completed four or more sessions: 2,321 of 3,046 (76%)
- 55% had diabetes (1,672)
- 42% African American, 5% Hispanic, 4% Asian, 2% American Indian/AK Native
- 21 counties

CDSMP

- 288 workshops
- Number who completed 4 or more sessions: 2,251 of 3,119 (72%)
- 27% had diabetes (833)
- 44% African American, 4% Hispanic, 8% Asian, 2% American Indian/AK Native
- 20 counties



Reaching Individuals with Diabetes – DSMP and CDSMP (2016 to present)

DSMP

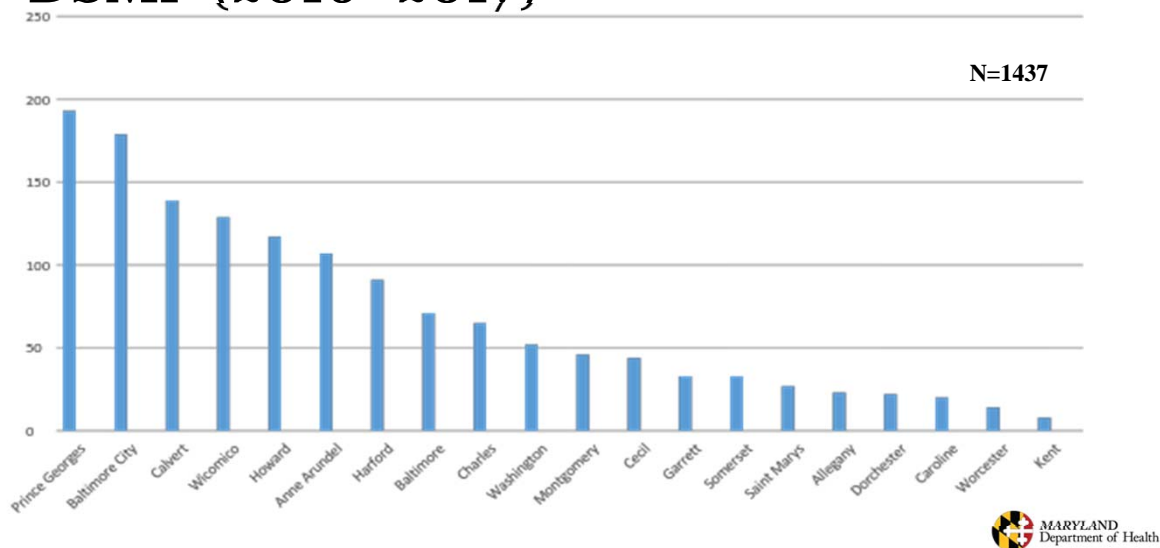
- 72 workshops
- Number who completed 4 or more sessions: 670 of 854 (78%)
- 55% had diabetes (472)
- 39% African American, 13% Hispanic, 3% Asian, 3% American Indian/AK Native
- 16 counties

CDSMP

- 62 workshops
- Number who completed 4 or more sessions: 459 of 583 (79%)
- 29% had diabetes (169)
- 49% African American, 4% Hispanic, 4% Asian, 2% American Indian/AK Native
- 15 counties



21 Counties Participated in CDSMP and DSMP (2016–2017)



Challenges

- No two hospitals, no two AAAs, no two LHDs are alike – so meeting these agencies on their levels takes time and patience
- The health care environment in Maryland is changing rapidly, which requires flexibility and ability to respond quickly
- Nineteen of twenty-one AAAs are county government

Successes

- MAC and AAAs have contracts/partnerships with 29 hospitals to implement chronic disease and diabetes self-management workshops
- Online autofill for provider referrals; partnerships with ACO providers increased referrals
- FQHC screens every individual for chronic disease and potential referral to self-management workshops
- MAC operates Maryland Access Point
 - Maryland's single entry system for Aging and Disability Resource Center
 - Risk assessment questions embedded and referrals made to workshops



Engaging the Aging Network, Health Care and Local Health Departments

- Regional leader trainings and update trainings
- Technical Assistance
 - quarterly webinars, power point presentations to engage health care providers, face-to-face meetings convening health care
- Development of Partnership Tools
 - Expanded consent forms and business agreements to share data (HIPAA compliant)
 - Tracking system: documents referrals, outreach, engagement, enrollment, workshop completion, patient self-efficacy measures, long-term action plans
- Presentations to hospitals to implement CDSMP and DSME
 - Collection of pre-/post- clinical measures
 - Partnerships across agencies to provide workshop leaders



Programa de Manejo Personal de la Diabetes Spanish Diabetes Self-Management Program Leader Training July 2016



Key Strategies for Success

- Risk assessments to identify/document participant health risks
 - Chronic disease, falls, depression, malnutrition/food insecurity
- BeHealthyMaryland.org statewide calendar of workshops for referral/enrollment
- Linking pre-/post- clinical measures to workshops
- Documentation of participant commitment to be better self-managers
- Quality assurance measures to identify potential problems/document program fidelity

Patient Activation and Self-Efficacy Alignment with NCQA Measures

- I have more self-confidence in my ability to manage my health than I did before taking this workshop
- I learned how to set an action plan and follow it
- I now have a better understanding of how to manage the symptoms of my chronic health condition(s)
- I feel more motivated to take care of my health since I took this workshop
- **New Question for 2017:** On a scale of 0 to 10, After taking this workshop, how confident are you that you can manage your chronic condition(s)



Quality Assurance Measures

- Adherence to workshop size requirements
- Workshop retention rates
- Reach to underserved populations
- Fidelity monitoring/adherence to certification requirements
- Non-disclosure agreements and Privacy Protection Training

Peer leaders

- Made me feel welcome and a part of the group
- Shared teaching responsibilities
- Were prepared when they came to class
- Were able to manage the group very well
- Got along well together
- Valued my opinions and contributions to the group



Success Stories

- It has been one of the most helpful classes I've ever taken.
- When a person is diagnosed with diabetes, it should be mandatory that they take a diabetic class like this.
- This class has made my life more enjoyable and less stressful.
- I no longer feel frustrated and overwhelmed.
- I now have the ability to take charge of my future by actively managing my diabetes.
- The massive amount of clarifying information and how to apply the knowledge was fantastic.
- This class has provided me with the keys to turn my bad habits into realistic good habits.
- Thanks for allowing us all to share and learn from each other.



Sustainability Efforts and Future Opportunities

- Leveraging multiple grants, grant applications, hospital contracts, and direct reimbursement (AADE Accredited DSMT, HBAI (Health Behavioral Assessment Intervention) to support and expand programs
- Bundling an array of evidence-based programs, and wrap-around services
- Veterans are a new priority population for EBPs and will increase the potential for funding via VA Choice and VA Home and Community-Based Services
- Targeted recruitment of minority populations (African American, Hispanic, Haitian) through outreach workers from these communities
- Expanded outreach to engage people with disabilities
- Planning to pilot offering EBPs and some wrap-around services within Chronic Care Management Services with ACO providers (Medicare reimbursement)



Johns Hopkins Bayview Medical Center

Tracy Knox, Central Maryland Coordinator, MCA, Inc.

July 18, 2017



Johns Hopkins Bayview Medical Center

- Johns Hopkins Geriatric Workforce Enhancement Program (GWEP), Division of Geriatrics



Community Programs

- Healthy Community Partners
 - 6 churches in the community
 - Lay Health Educator
- Called to Care
 - Respite Care Training
 - Caregiver Cafes
 - Caregiver 101



Hopkins Elder Plus



Community Partners

- Catholic Charities
- Health Departments
- Department of Aging
- STAR Program



Our Journey

- Resources
- Technology
- Challenges
- Team





DSME and DPP Overview

- 50 DSME providers in Maryland in 20 of 24 jurisdictions
- 61 DPP sites in 22 of 24 jurisdictions
 - 56 providers on DPRP site, including 3 YMCAs
 - 2 YDPPs
 - 3 affiliate locations



Addressing Best Practice in Diabetes Management

Marjorie Madikoto CFNP, CDE,MSA,BSN, RN

Program Director

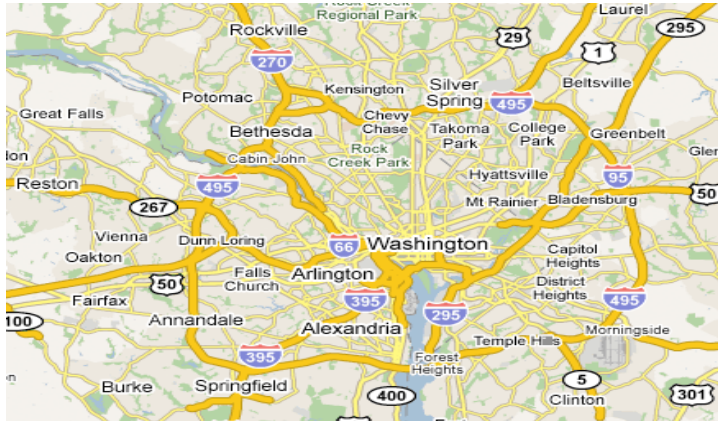


Background and Mission

DSCMI is a value based diabetes program that is based on a vision to expand diabetes education to all persons living with diabetes. The purpose of DSCMI is to give back to society a worthy cause that supports the wellbeing and growth of it's people. The Diabetes Self Care Management Institute is committed to delivering diabetes education that is personalized, empowering and evidence based.



The Community We Serve



Target Population

- Adults with prediabetes
- Woman with gestational diabetes
- Type 2 DM
- Type 1DM
- High school students transitioning to college



Recruitment of Participants

- Fliers
- Attending community based events
- Partnering with libraries in the community
- Social Media
- Letters to providers
- Partnering with providers



Barriers in Diabetes Education

- Lack of knowledge
- Rising incidence and prevalence of diabetes
- Treatment inertia
- Complexity of diabetes management
- Poor access to care
- Under referral by HCPs
- Location issues
- High patient attrition rate
- Poor reimbursement for DSME and chronic care management
- Cost of marketing



Overcoming Barriers

- Partnering with a local provider
- Participate in Provider group efforts for performance measures
- Involved in local diabetes forums and efforts
- Maintaining continued education in Diabetes
- Registered with CDC as a recognized partner in DPP
- Partnering with other diabetes communities e.g JDRF, DCN, ADA, MDADE, County school health program



Funding for DSCMI Program

- For profit entity
- Commercial payers
- Cash pay
- Medicare and Medicaid



Future Endeavors

- Expand services in Diabetes care
- Partner with other organizations
- To increase our service areas
- To expand mentorship for CDE's and new program
- Working with local hospitals
- Working with specialty providers
- Full credentialing with commercial payers

